Glen Rock Chiropractic Center
David A. Czerminski, DC
885 Lincoln Avenue
Glen Rock, NJ 07452
201-670-9093

ASSIGNMENT OF BENEFIT AND REPRESENTATIVE AUTHORIZATION

Date: _____
Patient Name: _____
Patient Address: _____
Patient City, State, Zip: _____
Emergency Name and Phone Number: _____
SS#/ID#: _____

I hereby certify that the insurance information that I have provided *Glen Rock Chiropractic Center*, on the Case History form, is true and accurate as of the date of service. I have made sure that if I have more than one insurance policy, all carriers have been contacted under the NAIC Coordination of Benefits Rules and applicable State Laws regarding Coordination of Benefits I certify that benefits, to pay any and all medical bills to provide me with medical care, I certify that I have obtained said authorization, from my Primary Care Provider or Health Insurance Company, in order to seek medical care from *Dr. David A. Czerminski.*

I understand that intentionally providing false insurance information may be considered fraud. I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my medical bill is paid in full. I also understand that my insurance company may not pay 100% of the amount of the medical claim and I may be responsible for any and all amounts not payable by my insurance company. I also understand that in the event that my insurance company performs a retroactive denial of my benefits, I am responsible for reimbursing the insurance company and not *Dr. David A. Czerminski.*

I hereby authorize *Dr. David A. Czerminski* to submit my claims for health benefits, on my behalf, to the insurance company listed on the copy of the current insurance card I have provided *Dr. David A. Czerminski*, in good faith. I fully agree and understand that the submission of a claim does not absolve me of my responsibility to ensure the claim is paid in full and that this courtesy can be revoked at any time.

I hereby instruct and direct _____ my health insurance companies, pay my health benefits, in full, and to make payment of health benefits, by check, made out and mailed to: *Glen Rock Chiropractic Center, 885 Lincoln Avenue, Glen Rock, NJ 07452.*

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If my current policy prohibits the assignment of my health benefits by making direct payment to *Dr. David A. Czerminski*, I also instruct and direct _____ Insurance Company to make out the check to me and mail it as follows: *Glen Rock Chiropractic Center, 885 Lincoln Avenue, Glen Rock, NJ 07452*, for the full and complete payment of my health benefits, and otherwise payable to me under my current insurance policy as payment towards the total charges for the professional services rendered.

This is a direct assignment of my rights and benefits under this policy. This payment will not exceed my indebtedness to *Dr. David A. Czerminski*, and I have agreed to pay *Dr. David A. Czerminski*, any balance of professional service charges over and above this insurance payment. Upon receipt of said check, I authorize *Dr. David A. Czerminski* to deposit checks received on my account when made out to me. I authorize *Dr. David A. Czerminski* to make deposit into the account of *Dr. David A. Czerminski* on my behalf.

I authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

I authorize *Dr. David A. Czerminski* to be my personal representative, which allows *Dr. David A. Czerminski* to: (1) submit my claims for health benefits, (2) submit any and all appeals when my insurance company denies me benefits to which I am entitled, (3) submit any and all requests for benefit information; insurance company policies and procedures; names and specialty of insurance company representatives that denied my health benefit; names, credentials and documents from any outside consultants or medical societies that had any part to the denial of my health benefits; and (4) initiate formal complaints to any State or Federal agency that had jurisdiction over my benefits. I fully understand and agree that I am responsible for full payment of the medical debt if my insurance company has refused to pay 100% of my benefits, within ninety (90) days of any all appeals or request for information. I also agree that any fines levied against my insurance company will be paid to *Dr. David A. Czerminski* for acting as my personal representative.

A photocopy of this Assignment shall be considered as effective and valid as the original.

_____	_____
Signature of Patient or Policy Holder	Date
_____	_____
Witness	Date
_____	_____
Signature of Claimant if other than Policy Holder	Date
_____	_____
Witness	Date